EXHIBIT B

MARICOPA COUNTY

Behavioral Health Benefits

January 1, 2003

United Behavioral Health

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Certification

CERTIFICATE OF INSURANCE

for Employees of

Maricopa County

(called the Employer)

insured by

UNITED HEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)

United HealthCare Insurance Company has issued Group Policy No. GA-(unassigned). It covers certain Employees of the Employer.

The policy provides Behavioral Health Benefits.

This Certificate of Insurance describes the benefits and provisions of the policy. Additional benefits and provisions may apply based on the requirements of:

- The state where the policy is issued.
- The state where the Employee lives.

These state benefits and provisions are described in separate Amendments. See the Employer for details.

This is a Covered Person's Certificate of Insurance only while that person is insured under the policy. Dependents benefits apply only if the Employee is insured under the Employer's Plan for Dependent Benefits.

This Certificate describes the Plan in effect as of .January 1, 2003

This Certificate replaces any and all Certificates previously issued for Employees under the plan.

UNITED HEALTHCARE INSURANCE COMPANY

Ronald B. Colby
Chairman & CEO

The Behavioral Health Benefits described in this Plan are administered by United Behavioral Health.

1-800-888-2998

C-CE1AZ, C-SB1, C-EL1, C-RE1, C-MH2, C-CI1, C-CB1, C-RP1, C-EM1, C-TE1, C-GL1

Schedule of Benefits

Effective Date of this Plan January 1, 2003

Behavioral Health Benefits

Covered Person's Responsibility		
	Network	Non-Network
Inpatient Copayment	$25 Per Day	Not Covered
Residential Treatment Copayment	$12.50 Per Day	Not Covered
Intensive Outpatient Copayment	$100 Per Program	Not Covered
Outpatient Individual Copayment	$10 Per Visit	Benefit covers $25 per visit
Outpatient Group Therapy Copayment	$5 Per Visit	Benefit covers $25 per visit

Maximum Benefits	Network	Non-Network
Mental Health/Substance AbuseCalendar Year Maximum Outpatient	30 individual visits Network and Non-Network combined 60 group therapy visits Network and Non-Network Combined	
Mental Health/Substance AbuseCalendar Year Maximum Inpatient/Residential	30 inpatient days 60 residential days	Not Covered
Mental Health/Substance Abuse Lifetime Maximum	Unlimited	$5,000,000

All benefits, except for Non-Network Outpatient Mental Health and Substance Abuse services are paid in accordance with the Reasonable Charge. Refer to the Glossary for the definition of Reasonable Charge.

Non-Network services are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services meet the Clinical Necessity criteria for Behavioral Health Services.

Eligibility

Eligible Employees

All Employees and retirees of the Employer enrolled in a Maricopa County sponsored medical plan. Employees must have their permanent residence in the United States

Eligible Dependents

Dependents are:

- A wife or husband of an eligible Employee.
- Any unmarried child from birth through age 19 of an eligible Employee.
- An unmarried child under age 25 of an eligible Employee, if the child is a registered student in regular full-time attendance at school. The child must be mainly dependent on the Employee for care and support. •
  A child under the age of 25 of an eligible Employee, if the child is a registered student in regular full-time or part-time attendance at school or is mainly dependent on the Employee for care and support or the child is living in the household of an eligible Employee. A child under age 25 on a church mission.

Child includes the following:

- A stepchild who resides in the eligible Employee's home.
- A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)
- Any other child related to an eligible Employee, mainly dependent on the eligible Employee for care and support and residing in the eligible Employee's home.
- Any unmarried child who is legally dependent on the Employee or the Employees Spouse.

Dependents must have their permanent residence in the United States

Cost of Coverage

The coverage under this Plan is contributory. This means that Employees must make contributions toward the cost of coverage.

Enrollment Requirements

Enrollment Date

The date the person is enrolled under this Plan.

Employee Coverage

An Employee enrolls for Employee coverage by:

- completing an enrollment form, and

- giving the form to the Employer.

An Employee's enrollment is either timely or late.

An Employee is considered a timely enrollee if he or she enrolls during either the Initial Eligibility Period or a Special Enrollment Period.

An Employee is considered a late enrollee when he or she enrolls during the Annual Enrollment Period.

Dependent Coverage

No person can be covered both as an Employee and as a Dependent.

Initial Dependents are those family members who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage.

Subsequent Dependents are any family members who become Eligible Dependents after the date the Employee first becomes eligible under this Plan. Subsequent Dependents may be added during a Special Enrollment Period.

A Dependent's enrollment is either timely or late.

A Dependent is considered a timely enrollee when he or she is enrolled for coverage during either the Initial Eligibility Period or a Special Enrollment Period.

A Dependent is considered a late enrollee when he or she enrolls during the Annual Enrollment Period.

Enrollment Periods

The Initial Eligibility Period is the 60-day period which begins on the date the person is first eligible under this Plan.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Annual Enrollment Period to enroll for coverage.

The Annual Enrollment Period is designated by the Employer each year. It is held before the start of each Plan Year. During this period, all eligible Employees and Dependents can enroll for coverage.

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents.

A Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Employee or Dependent.
- The Employee stated in writing, at the time coverage was previously offered, that the other coverage was the reason for declining enrollment under this Plan. The Employer must have requested the statement at that time. The Employer must have provided the Employee with notice of this requirement (and its consequences) at that time.
- The Employee's or Dependent's prior coverage was one of the following:
    - COBRA continuation which was exhausted.

- Non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

- The Employee requests enrollment under this Plan not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of Employer contribution.

A Special Enrollment Period is available to Subsequent Dependents. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

Late Enrollees

A late enrollee can enroll only during an Annual Enrollment Period.

Effective Date of Employee Coverage

Employee coverage is effective on the first day of the month coincident with or next following the latest of:

- The Effective Date shown in **Schedule of Benefits**.
-
- The first day of the pay period following 14 days after the date an enrollment form is received within 60 days of hire, unless, the Employee specifies a later date provided that date is the first day of a pay period.

Effective Date of Dependent Coverage

Coverage for an Initial Dependent(s) is effective on the later of the following dates:

- The date the Employee becomes covered.
- The date the Employee enrolls the Dependents.

Coverage for a Subsequent Dependent is effective as follows:

- For a spouse, the date of marriage.
- For a newborn child, the date of birth.
- For an adopted child, the date of adoption or placement for adoption.
- For any other child, the date the child becomes a Dependent.

Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for his/her children, these children can be enrolled as timely enrollees as required by OBRA 93.

If the Employee is not already enrolled, the Employee may also enroll as a timely enrollee at the same time.

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

Special Provision for Newborn Children

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

If additional contributions are required from the Employee for the coverage of that child, the Employee must enroll the child during the 31-day Special Enrollment Period in order for the child to be a timely enrollee.

Retired Employee Coverage

Retired Employees are eligible for the benefits as described below after they stop being an Active Employee.

As a Retired Employee, Plan Benefits are continued. The continued coverage will be the same coverage as for Active Employees, except as described below.

- The coverage for Retirees and Dependents is contributory. Retired Employees will have to pay the required contributions for the cost for their coverage.
- The continued benefits for Medicare Eligibles are modified as shown in **Medicare and Other Government Plans**.

Definitions

Retired Employee

Retired Employee means an Employee who meets all of the following:

- The Employee is retired by the Employer.
- The Employee receives retirement income either from the Employer or as a result of service with the Employer.
- The Employee was covered under this Plan or the Former Plan on the day before the date of retirement.

Totally Disabled or Total Disability

A Retired Employee's inability due to accidental injury or sickness to perform the normal activities of a person in good health and of like age and sex.

Behavioral Health Benefits

What This Plan Pays

Behavioral Health Benefits are payable for Covered Expenses incurred by a Covered Person for Behavioral Health Services received from either Network Providers (Inpatient and Outpatient Services) or Non-Network Providers(Outpatient Services only).

To receive the higher level of benefits, the Covered Person must call United Behavioral Health (UBH) before Inpatient Services are incurred. (See **Notification Requirements and Utilization Review.**)

Each Covered Person must satisfy certain Copayments and/or Deductibles before any payment is made for certain Behavioral Health Services. The Behavioral Health Benefit will then pay the percentage of Covered Expenses shown in **Schedule of Benefits**.

A Covered Expense is incurred on the date that the Behavioral Health Service is given.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Behavioral Health Services given. The Company, at its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with the methodologies:

- In the most recent edition of the Current Procedural Terminology and/or DSM IV Code;
- As reported by generally recognized professionals or publications.

Behavioral Health Services are services and supplies which are:

- Clinically Necessary, as determined by the Company, for Mental Disorder Treatment.
- Given while the Covered Person is covered under this Plan.
- Given by one of the following providers:
    - Physician.
    - Psychologist.

      Licensed Counselor.
    - Health Care Provider.
    - Hospital.
    - Treatment Center.

Behavioral Health Services include but are not limited to the following:

- Assessment.
- Diagnosis.
- Treatment Planning.
- Medication Management.
- Individual, family and group psychotherapy.
- Psychological testing.

Services and supplies will not automatically be considered Clinically Necessary because they were prescribed by a health care provider.

"Clinically Necessary" services or supplies are defined as services and supplies that meet all the following criteria:

Services or supplies are Clinically Necessary, as determined by the Company, if they meet all of the following:

- They are consistent with the symptoms and signs of diagnosis and treatment of the Covered Person's behavioral disorder, psychological injury or substance abuse.
- They are consistent in type and amount with regard to the standards of good clinical practice.
- They are not solely for the convenience or preference of the Covered Person, or his/her health care provider.
- They are the least restrictive and least intrusive appropriate supplies or level of service which can be safely provided to the Covered Person.

The Company may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations regarding whether particular services, supplies or accommodations provided or to be provided to a Covered Person were/are Clinically Necessary.

Notification Requirements and Utilization Review

To receive the higher level of benefits under this Plan (called the Network level) and not incur the penalties shown below, the Covered Person must call United Behavioral Health (UBH) before **inpatient** Behavioral Health Services are given. **The toll-free number is 1-800-888-2998. UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day.** This call starts the Utilization Review process. The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

Benefits under this Plan are reduced as follows if the Covered Person does not get a referral from UBH to a UBH Network Provider before **inpatient** Behavioral Health Services are given:

- Benefits are reduced by a $400 Non-notification Deductible as shown in **Schedule of Benefits**.
- Benefits are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services incurred meet the Clinical Necessity criteria for Behavioral Health Services.

If the Covered Person is not satisfied with a Network Provider, he/she may call UBH and ask for a referral to another Network Provider. The Covered Person may do this more than once, but he/she will only be referred to one Network Provider at a time.

UBH performs a Utilization Review to determine the Clinical Necessity of Behavioral Health Services. The Covered Person and his/her health care provider decide which Behavioral Health Services are given, but this Plan only pays for Behavioral Health Services that are Clinically Necessary as determined by UBH.

Appeals

The Covered Person may appeal a Utilization Review or benefit reduction. See How to Appeal a Claim Decision for further information.

Emergency Care

Emergency Care does not require a referral from UBH to a UBH Network Provider.

When Emergency Care is required for Mental Disorder Treatment, the Covered Person (or his/her representative or his/her health care provider) must call UBH within one day after the Emergency Care is given. If it is not reasonably possible to make this call within one calendar day, the call must be made as soon as reasonably possible.

When the Emergency Care has ended, the Covered Person must get a referral from UBH before any additional services will be covered at the Network level. If the Covered Person does not get a referral as required, benefits for any additional services are payable at the Non-Network level.

Copayments and Deductibles

Before Behavioral Health Benefits are payable, each Covered Person must satisfy certain Copayments and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Copayments are not counted toward any Deductible. Behavioral Health Services which require a Copayment are not subject to a Deductible.

A Deductible is the amount of Covered Expenses the Covered Person must pay before Behavioral Health Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentage shown in **Schedule of Benefits.**

The amount of each Copayment/Deductible is shown in **Schedule of Benefits**. A Covered Expense can only be used to satisfy one Copayment or Deductible.

Office Visit Copayment

The Office Visit Copayment applies to services given by a Network Provider. It applies to all services and supplies given in connection with each office visit.

Network Inpatient Copayment

The Network Inpatient Copayment applies to all services and supplies given in connection with each confinement in a Network Provider Facility.

Maximum Benefit

The Maximum Benefit payable for each Covered Person is shown in **Schedule of Benefits**. This maximum applies to each Covered Person's lifetime.

The Maximum Benefit includes any amount paid under the Employer's group health plan in effect on the day before the effective date of this Plan.

Extended Benefits

Extended Benefits are payable for a Totally Disabled Covered Person for up to 3 months. Extended Benefits are only payable for Behavioral Health Services given during the 3-month period after the person's coverage ends.

The person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Behavioral Health Services are given.

Extended Benefits are only payable for Behavioral Health Services given for the injury or sickness causing Total Disability.

Not Covered

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies which are not Clinically Necessary, including any confinement or treatment given in connection with a service or supply which is not Clinically Necessary.
- Services or supplies received before the Covered Person or his/her Dependent becomes covered under this Plan.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under this Plan.

- Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), autism, pervasive developmental disorders, chronic organic brain syndrome, learning disability, or transsexualism.
- Completion of claim forms or missed appointments.
- Custodial Care that has not been approved by UBH. This is care made up of services and supplies that meets one of the following conditions:
    - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
    - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

    Care that meets one of the conditions above is custodial care regardless of any of the following:

    - Who recommends, provides or directs the care.
    - Where the care is provided.
    - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's immediate family:
    - The Employee's spouse.
    - The child, brother, sister, parent or grandparent of either the Employee or the Employee's spouse.
- Services or supplies, treatments or drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, service or supplies.
- Services and supplies for which the Covered Person is not legally required to pay.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling.
- Occupational injury or sickness - an occupational injury or sickness is an injury or sickness which is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Behavioral Health Services.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-Clinically Necessary purposes, and related expenses for reports, including report presentation and preparation.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners humidifiers, saunas, hot tubs.
- Private duty nursing services while confined in a facility.

- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Stand-by services required by a Physician.
- Telephone consultations.
- Tobacco dependency.
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans or any related products.
- Services given by volunteers or persons who do not normally charge for their services.

Network Provider Charges Not Covered

A Network Provider has contracted to participate in the Network and provide services at a negotiated rate. Under this contract a Network Provider may not charge for certain expenses, except as stated below. A Network Provider cannot charge for:

- Services or supplies which are not Clinically Necessary;
- Fees in excess of the negotiated rate.

A Covered Person may agree with the Network Provider to pay any charges for services and supplies which are not Clinically Necessary. In this case, the Network Provider may make charges to the Covered Person. The Covered Person will be asked to sign a patient financial responsibility form agreeing to pay for the services that are found to not be Clinically Necessary. However, these charges are not Covered Expenses under this Plan and are not payable by the Company.

Claims Information

How to File a Claim

A claim form does not need to be filed when a Network Provider is used.

The following steps should be completed when submitting bills for payment:

- Get a claim form from the Employer, the Plan Administrator or United Behavioral Health.
- Complete the Employee portion of the form.
- Have the provider complete the provider portion of the form.
- Send the form and bills to the address shown on the form.

Make sure the bills and the form include the following information:

- The Employee’s name and social security number.
- The Employer's name and contract number (unassigned).
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

If the covered Employee asks for a claim form but does not receive it within 15 days, the covered Employee can file a claim without it by sending the bills with a letter, including all of the information listed above.

When Claims Must be Filed

The covered Employee must give the Company written proof of loss within 15 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of loss was given to the Company as soon as was reasonably possible.

How and When Claims Are Paid

All payments will be paid to the covered Employee as soon as United Behavioral Health receives satisfactory proof of loss, except in the following cases:

- If the covered Employee has financial responsibility under a court order for a Dependent's medical care, United Behavioral Health will make payments directly to the provider of care.
- If United Behavioral Health pays benefits directly to Network Providers.
- If the covered Employee requests in writing that payments be made directly to a provider. A covered Employee does this when completing the claim form.

These payments will satisfy the Company's obligation to the extent of the payment.

United Behavioral Health will send an Explanation of Benefits (EOB) to the covered Employee. The EOB will explain how United Behavioral Health considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee will receive a written explanation.

Any benefits continued for Dependents after a covered Employee’s death will be paid to one of the following:

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.
- A provider of care who makes charges to the covered Employee’s Dependents for Behavioral Health Services.
- The legal guardian of the covered Employee’s Dependent.

Legal Actions

The covered Employee may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee lives allows for a longer period of time.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for two years. It can be declared invalid due to nonpayment of premium.

No statement used by any person to get coverage can be used to declare coverage invalid if the person has been covered under this Plan for two years. In order to use a statement to deny coverage before the end of two years, it must have been signed by the person. A copy of the signed statement must be given to the person.

How to Appeal a Claim

If the Covered Person is not satisfied with a decision UBH has made regarding a request for Behavioral Health Benefits or payment of a claim for Behavioral Health Services, the Covered Person may pursue the levels of review available through UBH's appeals process. If the Covered Person has any questions regarding the Appeals Process, he or she should contact UBH at 1-800-888-2998. If the Covered Person participates in the Appeals Process, he or she waives any privilege of confidentiality of medical records regarding any person who examined or will examine the Covered Persons records in connection with the review process for the behavioral health condition under review.

The following levels of review are available to the Covered Person through the Appeals Process:

Expedited Review Process

This process is only available for the review of Behavioral Health Services that the Covered Person has not yet received. This process is not available for review of non-certified claims.

Expedited Clinical Review

In cases of non-certified services where a Physician or other Health Care Provider certifies that a delay will result in a significant negative impact to the Covered Person's behavioral health condition, the Covered Person or the Covered Person's representative may request an expedited medical review. UBH will resolve the request within one business day of the receipt of the request and all supporting documentation.

Expedited Appeal

If the Covered Person is not satisfied with the response at the expedited clinical review level, he or she may request an expedited appeal. The Covered Person must immediately submit a request to UBH. UBH will make a determination regarding the request within three business days of the receipt of the expedited appeal request.

Expedited External Independent Review

At any of the previous levels, UBH may escalate the Covered Person's request to the external independent review level. If the Covered Person is not satisfied with the outcome of a determination after an expedited appeal, he or she may request an expedited external, independent review. An external independent reviewer will make a determination within 15 business days of the receipt of the request for an expedited external independent review. The Covered Person's request must be submitted within five business days of receipt of the expedited appeal determination. UBH will acknowledge the request within one business day of receipt of the request for an expedited external independent review.

Standard Appeals Process

Informal Reconsideration

In cases of non-certified services where an expedited clinical review is not requested or necessary, the Covered Person or the Covered Person's representative may request, within two years of the non-certification, an informal reconsideration of the non-certification. UBH will acknowledge this request within five business days, and will make a determination regarding the request within 30 calendar days of receipt of the request for an informal reconsideration.

Formal Appeal

In the case of a non-certified claim, non-certified service, or if the Covered Person is not satisfied with the response at the informal reconsideration level, he or she may request a formal appeal. The Covered Person must submit a written request to UBH within 60 calendar days from the date of the response to an informal reconsideration, non-certified service or non-certified claim. UBH will acknowledge the request for a formal appeal within five business days of receipt of the request. In the case of a non-certified service, UBH will make a determination regarding the request within 30 calendar days, or in the case of a non-certified claim, within 60 calendar days of receipt of the request for a formal appeal.

External Independent Review

At any of the previous levels, UBH may escalate the Covered Person's request to the external independent review level. If the Covered Person is not satisfied with the outcome of a determination after a formal appeal, he or she may request an external independent review. An external independent reviewer will make a determination within 15 business days of the receipt of the request for an external independent review. External independent review requests from the Covered Person must be submitted in writing within 30 calendar days of receipt of the formal appeal determination. UBH will acknowledge the request within five business days of receipt of the request for an external independent review.

Contact Person for Processing the Review

If you have any questions regarding the appeals process, or need a copy of the Your Right to Appeal Packet, contact the UBH Appeals Unit at 1-800-888-2998, PO BOX 32040 Oakland, CA 94604 . Fax: 415-547-6259

Coordination of Benefits

Coordination of benefits applies when a covered Employee or a covered Dependent have health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Definitions

"Other Plans" are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.

"Primary Plan": A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

"Secondary Plan": Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

The benefits of this Plan will only be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of this **Coordination of Benefits** provision, whether or not claim is made, exceeds those Allowable Expenses in a Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
    - Medicare is secondary to the plan covering the person as a dependent.
    - Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

  If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - First, the plan of the parent with custody for the child.
    - Second, the plan of the spouse of the parent with the custody of the child.
    - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person such as another insurance carrier or a health care provider with an appropriate authorization form. The Covered Person must sign an authorization form in order for the Company to obtain the necessary information to coordinate benefit payments. If the Covered Person fails to sign an authorization form, this may impair the ability of the Company to evaluate or process a claim and may be the basis for denying claims for benefits.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any other source such as another insurance carrier or a health care provider. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information with the appropriate release form.

Right to Exchange Information

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Company will not have to pay that amount again.

Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Company may recover the amount paid from the other plan or organization or person.

The Company may pay benefits that are in excess of what it should have paid. The Company has the right to recover the excess payment.

Effect of Medicare and Government Plans

Medicare

When a Covered Person becomes eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

When This Plan Pays Primary to Medicare

This Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan for Covered Persons who are Medicare eligible if:

- The employee is a Retired Employee.
- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See How this Plan Pays When Medicare is Primary.

Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person should enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan or Medicare.

How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare eligibles. It does not apply to any Covered Person unless that Covered Person becomes eligible under Medicare.

If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating physicians), this Plan determines the amount of Covered Expenses based on the amount of charges allowed by Medicare.

If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating physicians), this Plan determines the amount of Covered Expenses based on the lesser of the following:

- The Reasonable Charges.
- The amount of the Limiting Charge as defined by Medicare.

This Plan determines the amount payable without regard to Medicare benefits. Then this Plan subtracts the amount payable under Medicare for the same expenses from Plan benefits. This Plan pays only the difference between Plan benefits and Medicare benefits.

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that **would have been payable to a Medicare eligible covered under Medicare even if:**

- The person is not enrolled for Medicare Parts A and B. Benefits are determined as if the person were covered under Medicare Parts A and B.
- The expenses are paid under another employer's group health plan which is primary to Medicare. Benefits are determined as if benefits under that other employer's plan did not exist.
- The person is enrolled in a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) to receive Medicare benefits, and receives unauthorized services (out-of-plan services not covered by the HMO/CMP). Benefits are determined as if the services were authorized and covered by the HMO/CMP.

Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

Termination of Coverage

Employee Coverage

Employee coverage ends on the earliest of the following:

- The day this Plan ends.
- The last day of the pay period in which employment stops. • The last day of the pay period in which the person stops being an eligible Employee.
- The last day of a pay period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due.

Dependent Coverage

Coverage for all of an Employee's Dependents ends on the earlier of the following:

- The day the Employee's coverage ends.
- The last day of a pay period for which contributions for the cost of Dependent coverage have been made, if the contributions for the next period are not made when due.

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent becomes covered as an Employee under this Plan.
- The last day of the pay period in which the Dependent stops being an eligible Dependent.

Continuation of Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as Dependents coverage under this Plan continues and the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

Glossary

(These definitions apply when the following terms are used.)

Calendar Year

A period of one year beginning with a January 1.

Covered Person

The Employee and/or Retiree and the Employee and/or Retiree's wife or husband and/or Dependent children who are covered under this Plan.

Emergency Care

Immediate Mental Disorder Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Employee

A person on the payroll of the Employer and regularly employed by the Employer on a full-time or part time basis of not less than 20 hours per week.

Health Care Provider

A licensed or certified provider other than a Physician whose services the Company must cover due to a state law requiring payment of services given within the scope of that provider's license or certification.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a hospital.
- It meets all of the following tests:
  - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
  - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
  - It is operated continuously with organized facilities for operative surgery on the premises.

Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Disorder Treatment

Mental Disorder Treatment is treatment for both of the following:

- Any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

A provider which participates in the network.

Non-Network Provider

A provider which does not participate in the network.

Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Osteopathy (D.O.).

Plan

The group policy or policies issued by the Company which provide the benefits described in this Certificate of Insurance.

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after behavioral health care has been received.

Pre-service Claims

Pre-service claims are those claims that require notification or approval prior to receiving behavioral health care.

Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable Charge

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Total Disability or Totally Disabled

- An Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation.
- A Dependent's inability to perform the normal activities of a person of like age and sex.

Treatment Center

A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board (if this Plan provides inpatient benefits at a Treatment Center).
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

Urgent Claims

Urgent claims are those Emergency Care claims that require notification or a benefit determination prior to receiving Mental Disorder Treatment.

Utilization Review

A review and determination as to the Clinical Necessity of services and supplies.

End of Certificate

Continuation of Health Coverage (COBRA)

This optional continuation only applies to Employees and their Dependents if it has been made available by the Employer. The Employer is required to offer this continuation in certain cases as a result of Public Law 99-272 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Employer to find out if and how this continuation applies to Employees and their Dependents.

In no event will the Company be obligated to provide continuation to a Covered Person if the Employer or its designated Plan Administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Covered Person in a timely manner of the right to elect continuation and notifying the Company in a timely manner of the Covered Person's election of continuation.

The Company is not the Employer's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

If coverage under this Plan would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the Qualified Beneficiary's health coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.
- If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or work hours being reduced, that Qualified Beneficiary may elect an additional 11 months of coverage under this Plan, subject to the following conditions:
    - The Qualified Beneficiary must provide the Employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
    - The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
    - If the Qualified Beneficiary entitled to the additional 11 months of coverage has nondisabled family members who are entitled to continuation coverage, those nondisabled family members are also entitled to the additional 11 months of continuation coverage.
- 36 months from the date the health coverage would have stopped due to the Qualifying Event other than those described above.

- For the spouse or dependent of an Employee who was entitled to Medicare prior to a qualifying event that is either the termination of employment or work hours being reduced, 18 months from the date of the qualifying event or if later, 36 months from the date of the Employee's Medicare entitlement.
- The date this Plan stops being in force.
- The date the Qualified Beneficiary fails to make the required payment for the coverage.
- The date the Qualified Beneficiary, after electing this continuation, becomes covered under Medicare or any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a Qualified Beneficiary's preexisting condition.)

If within the original 18 month continuation period, another Qualifying Event occurs, coverage can be continued for an additional period, for a total of 36 months from the date of the first Qualifying Event.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the date the person receives notice of the right to continue coverage.

Unless otherwise specified, an Employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

Notification Requirements

A Qualified Beneficiary must notify the Employer within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage is dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible Dependent.

The Employer will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

Conversion

At the end of this continuation period, a Qualified Beneficiary may be eligible for a conversion privilege if one is generally available under the plan.

Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

Special Terms that Apply to this Continuation Provision

Qualifying Event

A Qualifying Event is any of the following which results in loss of coverage for a Qualified Beneficiary:

- The Employee's employment ends (except in the case of gross misconduct).
- The Employee's work hours are reduced.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is dissolved.
- The Employee becomes legally separated from his/her spouse.
- The Employee's Dependent child stops being an eligible Dependent.

A bankruptcy is a Qualifying Event for certain Retired Employees and their Dependents under certain conditions. If there is a bankruptcy, Retired Employees should contact the Employer or the Company for more information.

Qualified Beneficiary

Any of the following persons who are covered under the plan on the day before a Qualifying Event:

- The Employee.
- An Employee's spouse.
- An Employee's former spouse (or legally separated spouse).
- A Dependent child, including a child born to or placed for adoption with the Employee during a period of continued coverage.

Continuation of Coverage During Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible Employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Employer to find out details about how this continuation applies to you.

Reasons for Taking Leave

FMLA leave must be granted for any of the following reasons:

- Care of a child after birth.
- Care of a child after placement of that child with the Employee for adoption or foster care.
- Care of the Employee's spouse, child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the Employee unable to work.

Employee Eligibility

To be eligible for FMLA benefits, all of the following must be true:

- The Employee must work for a covered Employer.
- The Employee must have worked for the Employer for at least 12 months.
- The Employee must have worked at least 1,250 hours over the previous 12 months.
- The Employee must work at a location where at least 50 employees are employed by the Employer within 75 miles.

Advance Notice and Medical Certification

The Employee must provide advance notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- If the need for the leave is unforeseen, notice must be given as soon as practicable.
    - An Employer may require medical certification to support a request for leave because of a serious health condition, and may require a second or third opinion (at the Employer's expense) and a fitness for duty report to return to work.

Continuation of Coverage, Job Benefits and Protection

For the duration of a FMLA leave, the Employer must maintain the Employee's coverage. The Employee may continue the Plan benefits for himself or herself and his or her Dependents on the same terms as if the Employee had continued to work. The Employee must pay the same contributions toward the cost of the coverage that he or she made while working.

If the Employee fails to make the payments on a timely basis, the Employer, after giving you written notice, can end the coverage during the leave if payment is more than 30 days late.

- Upon return from a FMLA leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

See the Employer for details about continuing group coverage other than the Plan benefits.

Intermittent Leave

Under some circumstances, an Employee may take a FMLA leave intermittently which means taking a leave in blocks of time, or by reducing his or her normal weekly or daily work schedule.

- Where a FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the Employer's approval.
- A FMLA leave may be taken intermittently whenever it is medically necessary to care for a seriously ill family member, or because the Employee is seriously ill and unable to work.

Substitution of Paid Leave

Subject to certain conditions, Employees or Employers may choose to use accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave. The Employer is responsible for designating if paid leave used by the Employee counts as a FMLA leave, based on information provided by the Employee. In no case can an Employee's paid leave be credited as a FMLA leave **after** the leave has been completed.

Spouses Who Work for the Same Employer

Spouses employed by the same Employer are jointly entitled to a **combined** total of 12 work weeks of family leave for the birth of a child or placement of a child for adoption or foster care, and to care for such child or to care for a parent who has a serious health condition.

Reenrollment after a FMLA Leave

If any or all of an Employee's coverages end while the Employee is on a FMLA leave, the Employee can reenroll for coverage when he or she returns to work from the FMLA leave.

The Employee and any Dependents will be considered timely enrollees if the Employee reenrolls within 31 days from the date he or she returns to work.